I. Appointment Requirements
   A. Minimum Requirements: the Nocturnist must have
      1. ABIM board certification or board eligibility in internal medicine.
      2. Faculty appointment in the Department of Medicine or appointment as a resident (fellow) at the PGY4 level or higher
      3. UC Irvine Medical Center teaching staff appointment in Internal Medicine or a UC Irvine School of Medicine appointment as a fellow (PGY 4 or higher) in an Internal Medicine subspecialty.
   B. Minimum Credentials: the Nocturnist will be capable of
      1. Evaluating and providing initial management of inpatients on the Medical Intensive Care (MICU) or Cardiac Care (CCU) services, with back-up from critical care faculty.
      2. Evaluating and providing care for patients on the general medical wards.
      3. Performing and teaching the following procedures: All central line insertions, paracentesis, thoracentesis, lumbar puncture, arterial line insertion.
      4. Providing documentation of current ACLS certification

II. Responsibilities and Expectations
   A. General Responsibilities
      The Nocturnist will be responsible during the night shift for maintaining the highest safety and quality of medical care provided by house staff (residents) on all Internal Medicine services, with emphasis on the MICU and CCU services.
      The Nocturnist will advise and supervise these residents, and will take direct responsibility for care when necessary.
      The Nocturnist will manage Internal Medicine resident resources when necessary to complete the night’s work (such as all overnight admissions) before morning. Only rarely will direct Nocturnist involvement be required, but it may include retasking floor or ICU residents to help each other, or more direct Nocturnist involvement.
   
   B. Core Responsibilities
      1. **Directly supervise of MICU/CCU residents**
      2. Personally evaluate each new admission to the CCU and MICU.
      3. **Document the Nocturnist’s evaluation of new admissions in a Quest “Event Note,” briefly summarizing key clinical issues, including history, exam, results, plan.**
      4. Be directly involved when any MICU or CCU patient clinically deteriorates
      5. **Succinctly document relevant information in a Quest “Event Note” when the Nocturnist intervenes or changes the plan.**
      6. **Supervise the following procedures, or personally perform them if no resident is capable: central line insertion (all sites), arterial line insertion, thoracentesis, paracentesis, lumbar puncture.**
         *Always assess the resident’s experience level and certification before procedures. Supervise procedures from start to finish appropriately for resident competence.*
      7. Arrive at 6PM or earlier for in-person signout with the MICU and CCU fellows. This signout should focus on high-level issues like:
         1) Which patients are most acute
         2) What active issues require immediate or ongoing management
      8. Participate directly in resident signout – fellow signout takes priority.
      **EFFECTIVE SIGNOUT IS EXTREMELY IMPORTANT!!!**
C. Additional Responsibilities

1. Consider needs for urgent consultation – particularly for new or deteriorating patients. Advise/supervise MICU/CCU residents accordingly.
2. Personally check on all MICU and CCU patients for safety and quality, and assess the progress of care plans. Unless there are conflicting emergencies, these rounds should happen after signout and again around midnight. For sick or deteriorating patients, visit frequently and remain involved until the situation stabilizes.
3. Twice nightly at convenient times, call the medicine ward residents to determine if any assistance is needed and to briefly discuss complicated cases. Such assistance may include anything the Nocturnist feels is appropriate - even taking over some of the work for the Resident if the Nocturnist feels that is needed to avoid problems with quality of care or safety.
4. Triage care and delegate immediate actions when MICU/CCU services are very busy.
5. Directly supervise medicine ward residents when necessary. IF THE MEDICINE RESIDENTS CALL YOU FOR HELP FOR ANY REASON, PLEASE PROVIDE ASSISTANCE. See “limitations” below for parameters.
6. Speak with family members when possible, particularly if it will improve the quality of care and the visibility of that quality.
7. On very rare occasions, admit or care for patients without the resident when residents are unable.
8. If the Nocturnist is faculty, sign DNR/DNI forms for newly-admitted medicine patients. The resident should bring the form to the Nocturnist for signature. Primary attendings must still be notified for any code status changes or deaths.
D. Expectations:
1. **Arrive at the MICU no later than 6 PM for sign-out rounds with the MICU and CCU fellows, followed by direct involvement in resident signout.**
2. Report admissions and issues that the Nocturnist was involved in to the MICU fellow at the end of a night shift – either in person or by phone. (Also see #15 below)
3. Remain in or adjacent to the MICU as much as possible for the entire shift, unless evaluating patients in the ED or otherwise fulfilling Nocturnist responsibilities.
4. Remain available to MICU/CCU and ward residents the entire shift.
5. Carry the floatpager #1010 at all times during a night shift.
6. Make sure the residents are comfortable contacting the Nocturnist for any concerns.
7. Call the Medicine ward resident near the beginning of the shift to plan/schedule discussions of admissions during the night.
8. Speak with the MICU senior resident every 4 hours or more frequently.
9. See new MICU and CCU admissions early – in the Emergency Department, if possible.
10. Document Nocturnist involvement and key clinical details for all new admissions or significant clinical changes in which the Nocturnist is involved.
11. Be professional in discussions with consultants and with the Emergency Department.
12. If the Nocturnist feels a patient should be downgraded from ICU, write a note. This should only be done if absolutely necessary, and the ICU team is responsible for the care of the patient over night until a proper handoff to the ward team in the morning can be done.
13. If conflicts arise, place the patient in the safest situation. This will often mean admission to the MICU or CCU. **DO NOT argue about admissions.** Refer to admission policies or call the on-call fellow or attending for advice, but ultimately conflicts should be resolved in the morning among the various service chiefs. The Department of Medicine policy is the patient goes to the safest place if there is any question or doubt by anyone.
14. Call the medicine Chief Resident on call if the Nocturnist believes resident back-up needs to come in.
15. The on-call MICU fellow must be notified of major clinical changes:
   - new intubation
   - significant ventilator escalation
   - new or significantly escalated pressors
   - significant neurologic change
   - emergent need for surgery
   - codes blue
   - unexpected deaths
   - situations in which the Nocturnist is uncomfortable.

If the Nocturnist is a critical care fellow, this notification may happen before the end of the night shift at 6AM – to facilitate a smooth transition of care.
If the Nocturnist is not a critical care fellow, notification should happen as the situation develops. The on-call fellow will alert the critical care attending on call when needed. If needed, the critical care or cardiology fellow on call or attending is expected to come in to the hospital.

16. Be visible to nurses on medicine floors in addition to your ICU rounds. **Once per shift walk to 3T, 4T, and 5T and identify yourself as the medicine Nocturnist.**
17. At the end of each month complete a monthly time sheet and submit it to the Department of Medicine by the first working day of the next month.
III. Limitations of Nocturnist Responsibilities

1. The Nocturnist will not be the initial point of contact for admissions from the Emergency Department. The resident must notify the Nocturnist very soon after admission is requested, so the Nocturnist can evaluate the patient in a timely manner.

2. The Nocturnist will not routinely make ICU admission decisions. The Nocturnist should only intervene in these decisions if the resident wishes to downgrade a patient from ICU status, if the decision is not clear, or if there is a safety or quality concern.

3. Nocturnists ARE NOT expected to be independent critical care physicians. Nocturnists should feel comfortable contacting critical care fellows or faculty IMMEDIATELY when they feel it is required for safe, quality care.

4. The Nocturnist IS NOT the leader of the Code Blue Team. This remains the role of the MICU senior resident. In many situations, the Nocturnist should attend Codes Blue, but the Nocturnist must use judgment to decide if he or she should rather remain in the MICU or CCU to provide immediate care to critical patients.

5. The Nocturnist is NOT expected to perform endotracheal intubation unless the situation is truly emergent and no other options exist. There is a 24/7 emergency airway team at UCI for urgent and emergent intubations.

6. Unless there is a suggestion of a safety or quality problem, the Nocturnist is not responsible for detailed supervision of all aspects of care for general medicine ward patients. This would detract from the primary responsibility in the MICU and CCU.

7. With the exception of procedures, teaching is a secondary goal for the Nocturnist – after the primary goal of ensuring safety and quality care.

8. The Nocturnist is NOT the admitting attending for general medicine ward patients or for ICU patients, and should not be listed as the cosigner on H&P’s.

9. The Nocturnist is NOT the on-call medicine consult attending. However, Nocturnists with faculty appointments have discretion to get involved with urgent medicine consults, if appropriate. Medicine consults should never interfere with the Nocturnist Responsibilities and Expectations.

10. The Nocturnist is NOT the in-house resident backup for completing work on stable patients. If the floor medicine residents call for assistance, the Nocturnist should make a real effort investigate and determine if/how the Nocturnist’s involvement can best help the situation - being professional in all interactions. This may include assistance with triage, helping residents prioritize their work, stabilizing situations, helping with admissions, calling in resident backup, or whatever assistance the Nocturnist feels is most appropriate to prevent safety or quality problems. Helping residents complete non-urgent work must never compromise the Core Responsibilities and Expectations.
IV. Scheduling

A. Definitions:
   1. Unrestricted Night Shifts: shifts NOT followed the next day by clinical duties.
   2. Restricted Shifts: these are night shifts followed the next day by clinical duties

B. Policies
   1. PGY4: May not work ANY restricted Shifts
   2. PGY5 and up: May work up to two restricted shifts per calendar month if it does not interfere with clinical duties.
   3. No Fellow may work night shifts if the next day involves patient work on an ICU rotation or any rotation specified by their fellowship program.
   4. Faculty: May work up to two restricted shifts per calendar month, but restricted shifts must occur at least 5 days AFTER any other night shift, to reduce fatigue.
   5. **FELLOWS MAY NOT WORK NIGHTS WHEN THEY ARE ON CALL** for the fellowship.
   6. Fellows may work up to 12 shifts per quarter